Virginia Department of Health
Monthly Clinical Assessment

Name _____ **DOB** ____/____/_____ **VISION #** _____

RX #s:

Case/suspect	Date	Date	Date	Date	Date	Date
Treatment Month						
Weight (Monthly)						
Temperature (PRN)						
Blood Pressure (1st Visit, then PRN)						
Assessment						
Cough: Frequency						
Sputum: Amount/color						
Night sweats/Fever						
Appetite change/weight loss						
Fatigue						
ETOH/Substance abuse						
LMP/ FP method						
Side Effect/Toxicity						
Loss of Appetite						
Nausea/Vomiting/GI symptoms						
Urine Color Change (Dark)						
Rash/itching						
Numbness/Tingling (Hands/Feet, Face/Mouth)						
Change in Vision/Hearing (if appropriate)						
Jaundice (Yellow Skin/Eyes)						
Flu-like Symptoms						
Fatigue						
Headaches						
Fever						
Joint Pains/Swelling						
Vertigo/Dizziness/Fainting						
Hearing Loss/Ears Ringing/Fullness						
Mood Changes/Depression						
Tests						
Sputum	NA Cans given Collected	NA Cans given Collected	NA Cans given Collected	NA Cans given Collected	NA Cans given Collected	NA Given Collected
Visual acuity	NA/Done	NA/Done	NA/Done	NA/Done	NA/Done	NA/Done
Hearing	NA/Done	NA/Done	NA/Done	NA/Done	NA/Done	NA/Done
Blood work	NA/Done	NA/Done	NA/Done	NA/Done	NA/Done	NA/Done
Other (specify)						
Compliance	DOT/other	DOT/other	DOT/other	DOT/other	DOT/other	DOT/other
# Missed Doses						
Medications Issued						
Number of Days Given						
Next Appointment/Refill Due						
PHN Initials						
Patient Signature or Initials						

PHN Signature	Initials	Interpreter	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____